Let me begin by thanking the Regional Director, Dr Ala Alwan, and the Government of Oman for their invitation to attend this Regional Committee meeting, my first, and for their generous welcome and hospitality.

I am especially grateful to Dr Alwan. My experience of WHO is that speeches have to be cleared well in advance of their delivery. That is not the case this evening. What follows should perhaps be labelled with a government health warning: this is not an official WHO speech.

The beginning of my relationship with countries in the Eastern Mediterranean Region was inauspicious. It began on the cramped first floor of an office block above a noisy garage in Ramallah, on the West Bank of the occupied Palestinian territory. It was 2007. I was in a small seminar room with a team of public health scientists from Birzeit University.

We wanted to ask and answer what we hoped might be several interesting questions. Could a group of health researchers from the occupied territory tell their story about life lived under occupation? Could they use the tools of public health to challenge prevailing western views about the occupied territory? Could science and health be forces for truth-telling and even political advocacy? Our expectations seemed hard to satisfy.

But, over the next 12 months, this team built an extraordinary collaboration, including universities in the occupied Palestinian territory, the Ministry of Health within the Palestinian Authority, WHO's country and regional offices, UNRWA, and universities across the Arab World. In March, 2009, the series on health in the occupied Palestinian territory was published and launched in Ramallah and London.

That collection of papers and comments spoke specifically to issues in Gaza, the West Bank, and East Jerusalem. But they were also intended to be generalisable to the region. The importance of history, especially western colonialism, in shaping nation-states and so national health systems. The idea of a health system existing under chronic conflict. The need for new measures of health (such as social suffering) to reflect the realities of life under occupation and conflict. The unfinished agenda of maternal and child health, including, importantly, reproductive health. The new challenges of cardiovascular disease, diabetes, and cancer, together with their risk factors—tobacco use, hypertension, and high cholesterol. And the linkages between health and human security, or too often the lack of human security. Tonight, I'd like to recognise the contribution of Awad Mataria to that work. He is here this evening and now works for the WHO Regional Office.

If I may be allowed to say so, the response to this series was remarkable. It was and remains the most rapidly downloaded series of any Lancet project we have published. The demand for reliable knowledge about the Palestinian predicament is high.

We drew three lessons from this work.

First, creating a network of public health scientists in a country, and linking it with global scientific networks, can achieve something novel and powerful. It not only allows a people to tell their own historical, political, and social story through science, but also delivers evidence to decision-makers, mobilising their confidence to act.

Second, a state—even a state under occupation—can provide fresh and important leadership in global health using health as a diplomatic tool, an instrument of foreign policy, and as a potent political lever to achieve the right to health and health equity.

And third, one can use health perspectives not only to evaluate the health of individuals and communities, but also the health of whole nation-states.

This work on the occupied Palestinian territory shows, I think, the power of science and the research community, through national and regional collaborations, to support your Regional Director's five priorities—accelerating progress on the MDGs, acting on the challenge of noncommunicable diseases, building capacity for emergency preparedness, protecting people from emerging infectious diseases, and strengthening health systems to achieve universal health coverage. The announcement today of confirmed cases of polio in Syria and the epidemic disease threat to regional health security only underlines the importance of aligning research with these strategic health priorities.

The work on Palestine is certainly helpful, I believe, in supporting the region's health priorities. But we have tried to take this initiative one step further. When we launched our report in March, 2007, I made a personal commitment to return annually to monitor and measure the progress our series had sought to accelerate, to devise ways to strengthen public health capacity in the region, and to help facilitate the translation of the evidence we published into policy.

In 2010, we returned to Ramallah, in 2011 to Beirut, in 2012 to Cairo, and in 2013 to Beirut again. We hold annual research conferences and writing workshops with our partners to provide young scientists with opportunities to present new work, to learn better skills for science and advocacy, to connect them with policymakers, and to enable their voice to be heard in public health decision-making.

This experience provided another opportunity to look for other countries that might use science to advance health and strengthen their political voice in the region. Our gaze turned to Pakistan. Thanks to Sania Nishtar, the President of Heartfile, an NGO that works on non-communicable diseases, we supported a new collaboration between WHO, the Government of Pakistan, NGOs, and universities. That collaboration identified four priorities for Pakistan's health advancement—defeating the very real and continuing threat of infectious disease, learning from natural disasters that all too frequently afflict Pakistan, analysing the effects of health reforms (such as the 18th Constitutional Amendment) on health, and reaffirming Pakistan's commitment to accelerate progress on the health-related MDGs and the post-2015 non-communicable disease agenda.

Amassing this scientific evidence allowed us also to propose a call to action to Pakistan's government. Part of that call to action was to emphasise the importance of political ownership of health (federally and provincially), to stress the value of investing in health (in the health and non-health sectors, such as nutrition), and to invite political leaders to embrace a strong and ambitious vision for health.

By a stroke of incredible good fortune, our series on Pakistan finished at exactly the same moment that Sania Nishtar became interim Minister of Health in the government. When we launched the series in Islamabad in May this year, we hope we were able to trigger a wider public debate about the future of health in the country after the election. And we hope, very modestly, that the conclusions the series draws are helpful to the new Government of Pakistan.

As with Palestine, a more general set of lessons emerges from this work on Pakistan. A research-productive nation, which Pakistan certainly is, provided crucial evidence not only for itself but also for countries well beyond Pakistan's borders. This research culture creates an environment for innovation—from Lady Health Workers to school-based mental health programmes. And the serious attention given to science and health in the country positively influences the conditions that enable new leaders to emerge in health at home and abroad, strengthening Pakistan's (and the region's) voice in global political dialogue.

And now we look forward to our most ambitious scientific collaboration yet—The Lancet Arab World Series, to be launched in January, 2014. Again, let me acknowledge the contribution of Samer Jabbour, also here this evening, in co-leading this work. Seventeen countries from the Region are authors in this series, showing a remarkable degree of regional cooperation.

The obvious goal of our Arab World Series has been to capture evidence that resonates with global debates around health—the global burden of diseases, injuries, and risks; noncommunicable diseases; reproductive health; and universal health coverage. But we also wanted to investigate distinctive and sometimes difficult issues relevant to the entire region—how health systems must continuously adapt to the often dramatic political changes taking place in the Arab World today; how health is connected to the evolution of Arab States and their development; the changing geographies of war and their effects on health; and the relationship between effective government (and governance) and health.

Let me try to draw these elements together into a final statement. Our goal is to show that countries of the Region have a distinctive, but too often silent, ignored, and marginalised, contribution to make to global health. Today, only a few largely western voices dominate debates in global health. We want to expand that conversation, to make sure the countries of the Region play their part fully.

We have been fortunate to work with many of your countries in other collaborations too—with Iraq on civilian mortality after the western-led invasion in 2003; with Saudi Arabia on mass gatherings; and, only last week, at the World Health Summit in Berlin, with UNRWA to present work on catastrophic health expenditure and universal health coverage. And we have further plans for collaborations in Islamic Republic of Iran and Afghanistan.

Of course, I recognise that, as an outsider, I must be careful not to make facile generalisations in a Region characterised by incredible diversity. But to end let me offer four tentative conclusions.

First, that investments in reliable health information, knowledge, and science—and investments in the institutions that generate reliable information, knowledge, and science—build skills for better political and public health decision-making in the quest for health equity and universal health coverage.

Second, these investments in health are critical not only for health and human security, but also for national security. Strong health systems are indispensable for protecting the integrity of the nation-state.

Third, multilateral institutions, such as WHO, play an essential part in supporting and sustaining these actions for health in your countries. But multilateralism is facing a crisis. Lack of funding of multilateral institutions is eroding their ability to be strong intergovernmental mechanisms to promote cooperation and enable all voices to be taken seriously.

And finally, the networks and collaborations I have described provide a vital platform for regional leadership in health and development, your leadership in global health.

Let me end on a personal note. In March this year, I was in the Shatila refugee camp in Beirut. The camp had seen an influx of thousands of refugees from Syria. I sat on the floor of one family's one-room apartment, with a mother, her four children, her husband and other relatives. They had escaped a civil conflict, but their futures still remained fragile, vulnerable, and bleak. The next day, I returned home to my family, to my wife and daughter, in London, a very long distance indeed from the lives of families in Shatila.

We often talk about health systems, universal health coverage, the MDGs, NCDs, and post-2015. These are abstract concepts that mean very little to ordinary families, such as the one I sat with in the Shatila camp. But the lives within this family were not abstract at all. They were all too real. They faced real danger, real risk, and real fear. And, of course, like all of us, they possess real hopes too. It is that family, and the millions of families like it, who should be our measure of success in this region.

This is a region that has displayed enormous vision for health. It has many successes to be proud of. And it has the resources to do more. Let's continue to strengthen our resolve and succeed for our peoples—together.

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